Community Based
Monitoring and Planning
in Maharashtra

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COPASAH

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CENTRE FOR HEALTH AND SOCIAL JUSTICE

Foreword

The world today is becoming increasingly complex and relatively simpler development aspiration of poverty alleviation has become complicated with a whole range of concerns including economic issues income inequalities to social issues like inclusion and environmental issues like climate change which affect both the rich and the poor people and nations. Participation, transparency and accountability are being seen as common principles which help to navigate the process of coming to consensus solutions. COPASAH (Community of Practitioners on Accountability and Social Action in Health) is a collective of practitioners who have been applying these principles in the field of health governance in different places around the world. Health care is a contested area of governance and public policy action. In many countries, especially in the Global North, it is provided through state support, whereas in many countries in the Global South public services are in disarray and the private sector is flourishing, creating huge inequalities in access and health outcomes. 'Privatisation' and 'fee for service' are a common refrain from many development think tanks, while a case for 'universal health care' is put out by others.

While cost of care and nature of public or private provisioning continues to be matter of public debate, it is undeniable that there is a huge power asymmetry between people, especially poor people in distress and providers. This power asymmetry affects the ability of the poor to access services in their best interests. In many countries communities have themselves come together to negotiate better health care services from the state. In this Case Studies series we wish to highlight some of these organised efforts. These case studies describes the work of colleagues in COPASAH, outlining how they conceptualised, organised and implemented these processes, drawing upon the principles of participation, transparency and accountability.

We hope these Case Studies will serve as stories of hope and inspiration for other practitioners to adopt similar practices while we strive for better health outcomes and for health equity in our common march toward health for all.

About Authors

The authors are affiliated to SATHI. SATHI is the Action Centre of Anusandhan Trust based in Maharashtra state of India. In pursuit of the goal of "Health for all," SATHI works to strengthen coalitions at local, state and national levels towards ensuring universal access to quality health services in a rights-based framework. Presently SATHI's work spans three major areas: 1) Community based monitoring – as the state nodal organisation in Maharashtra, SATHI implements community based monitoring and planning with support from the National Rural Health Mission (NRHM), in collaboration with 25 partner civil society organisations. 2) Patient's rights and social accountability of private medical sector – the SATHI team has played a pioneering role in promoting patient's rights in the private medical sector in Maharashtra over the last decade. 3) Health system research and related advocacy – SATHI conducts research on areas like access to Health care and Health related inequities, procurement and availability of medicines, utilisation of flexible funds, malnutrition, etc. SATHI is presently coordinating policy research to propose a Public-centred system for Universal health care in Maharashtra.

For more information about SATHI, see www.sathicehat.org

Community Based Monitoring in Maharashtra

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Executive Summary

The National Rural Health Mission (NRHM) launched in 2005 in India articulated provisioning of universal access to equitable, affordable and quality healthcare, especially for people residing in rural areas, women, children and poor. With a view to increase people's participation for improving health governance and strengthen the community interface with the public health service system NRHM outlined Community Based Monitoring of health services as an effective strategy. The case study: Community Based Monitoring and Planning in Maharashtra, analyses the diverse experiences of community action for accountability of health services that have emerged in the state of Maharashtra in India, after the NRHM came into being. The focus is on drawing out lessons from organising several hundred Jan Sunwais (Public hearings) and dozens of 'stories of change' associated with this process. The strategies discussed will be of value for health and social activists working for accountability of public services in various contexts across the world.

Abbreviations

AGCA Advisory Group for Community Action

ANM Auxiliary Nurse Midwife

ASHA Accredited Social Health Activist – Rural community health worker

AWW Anganwadi Worker – Community level worker responsible for Child nutrition and development centre

ADHO Additional District Health Officer

CBMP Community Based Monitoring and Planning

CBM Community Based Monitoring

CBP Community Based Planning

CHC Community Health Centre

CS Civil Surgeon

CSO Civil Society Organisation

DHO District Health Officer

DH District Hospital

GP Gram Panchayat – Elected village council

JAA Jan Arogya Abhiyan – People's Health Movement, Maharashtra

JSA Jan Swasthya Abhiyan – People's Health Movement, India

JS Jan Sunwai – Public hearing

MLA Member of Legislative Assembly

MP Member of Parliament

NRHM National Rural Health Mission

PHC Primary Health Centre

PIP Programme Implementation Plan

PS Panchayat Samiti – Block level self government body

PRI Panchayati Raj Institution – Elected self government body

RH Rural hospital

RKS Rogi Kalyan Samiti – Health facility management committee

SC Sub-centre

VHSNC Village Health, Sanitation and Nutrition Committee

ZP Zilla Parishad – District level self government body

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Chapter 1

Background

The most extensive community accountability initiative currently underway in the health sector in India is taking place within the framework of India's National Rural Health Mission (NRHM). NRHM was launched in 2005, and while the first phase ended in 2012, the Health Ministry has decided to launch a second phase from 2012–2017. The Mission aims to improve the quality of health care through implementation of a health systems strengthening approach, hence the NRHM framework represents a conscious decision to strengthen public health systems and the role of the State as health care provider. NRHM recognized the need to give special attention to the following issues, each of which is made up of a number of overlapping core strategies:

- Sufficient budgetary allocation for public health
- Providing quality and effective health services to the rural population, with a special focus on women, children and poor people
- Improved access to health services
- Strengthening and decentralization of health services
- Increasing people's participation in health services

The Mission lists a set of core strategies to meet its goals like decentralized village and district level health planning and management, and appointment of female Accredited Social Health Activists (ASHAs) to facilitate access to health services. The Mission attempts a shift in the governance of public health by assigning prominence to Panchayati Raj Institutions (elected self–government bodies) in matters related to health at district and sub–district levels, coupled with decentralised district level management of health services.

The efforts by NRHM need to be viewed in context of historical neglect of preventive health care in India and the backdrop of dominance of the private sector in the delivery of health services. The public sector in health exists without a minimum legislative framework. 'In the absence of law making it mandatory to provide the stipulated minimum health care, citizens are not able to exercise any right over the quantity and the quality of health care provided'.[1] Moreover, declining public investment and expenditure in health is compounded by the fact that the system is not only heavily bureaucratised, but is also marked by corruption, inadequate infrastructure, and inadequate availability of skilled staff and medicines. In this context, community based monitoring has been viewed as an important step for promoting accountability and community led action in the field of health.

...declining public investment and expenditure in health is compounded by the fact that the system is not only heavily bureaucratised, but is also marked by corruption, inadequate infrastructure, and inadequate availability of skilled staff and medicines.

[1]   Jesani, A. (2002): "Social Objectives of Health Care Services: Regulating the Private Sector". In K. Seeta Prabhu and R. Sudarshan eds, Reforming India's Social Sector: Poverty, Nutrition, Health and Education. Social Science Press, pg 112, New Delhi .

Community Based Monitoring and Planning (CBMP)

India has a long history of civil society activism on health issues. The national campaign platform for health rights – *Jan Swasthya Abhiyan* (JSA), the Indian section of the People's Health Movement – has frequently raised the above mentioned concerns at the state and national levels. Upholding the right to health care, JSA has strongly advocated for improvement and strengthening of public health system. In 2006, a Task Group on District Health Planning was constituted by the Health Ministry. JSA activists who were part of the task force, strongly urged adoption of community based monitoring, which was subsequently incorporated in the NRHM framework. The National Advisory Group for Community Action (AGCA) that was formed as part of NRHM further proposed concrete steps which led to the launching of CBMP with support from NRHM.[2] The Advisory Group recommended that the approach be piloted in nine states[3] before being rolled out at national level. The pilot phase began in 2007 and ended in 2009. By 2012 several states had incorporated community mobilization into their Program Implementation Plans (PIP).[4]

Community monitoring, internal monitoring through Health management information systems and periodic external surveys together comprise the overall framework of generating information for monitoring in context of NRHM. However, community monitoring is conceptualized as being more than a data gathering exercise; it is also a key strategy for ensuring that health services reach the people who need them (through community inputs to local level planning), and for ensuring public accountability for service delivery failures (See Box 1: Objectives of Community Monitoring in context of NRHM). In other words, through various NRHM health service interventions, the supply side of Health services is expected to be strengthened, while the demand for Health services from the community is sought to be promoted through the community based monitoring process.

The theoretical underpinnings of CBMP can be condensed into three key inter–related concepts, citizenship, democratization and rights. CBMP is closely related with the exercise of citizenship. An evolving democracy envisages a growing role for citizens in the monitoring of bureaucracy and functionaries. Hence several legislations of the last decade beginning with the right to information have increasingly empowered the public to call for accountability of public servants. CBMP as a process of democratization, recognizing and restoring power to citizens acting collectively, is reflected in the exercise of people's power (demos + kratia) to affirm the centrality of the citizen in the governance of health services. Democratization also envisages equalisation of power relations between the public and public servants, with recognition that the public servant as duty bearer is accountable to the public as rights holders. Hence CBMP as a step in the direction of democratization seeks to bridge the distance between the

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2   SATHI (2012): People are Reclaiming the Public Health System Qualitative Report of CBMP of Health services in Maharashtra, pg 6, Pune.

3   The nine states are – Assam, Chhattisgarh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Orissa, Rajasthan and Tamil Nadu.

4   http://mohfw.nic.in/NRHM/Documents/Mission_Document.pdf. Accessed on 24th Sep 12.

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hitherto powerless citizen (rights holder) and the largely unaccountable official (duty bearer) by mediating an accountability matrix which gives people collectively both voice and agency.

BOX 1: OBJECTIVES OF COMMUNITY MONITORING IN CONTEXT OF NRHM

The Manual on Community Based Monitoring of Health Services under National Rural Health Mission, prepared by the Advisory Group for Community Action envisages that community monitoring will do the following:

- It will provide regular and systematic information about community needs, which will be used to guide the planning process appropriately;

- It will provide feedback according to the locally developed yardsticks, as well as on some key indicators;

- It will provide feedback on the status of fulfillment of entitlements, functioning of various levels of the public health system and service providers, identifying gaps, deficiencies in services and levels of community satisfaction, which can facilitate corrective action in a framework of accountability;

- It will enable the community and community-based organizations to become equal partners in the planning process. It would increase the community sense of involvement and participation to improve responsive functioning of the public health system. The community should emerge as active subjects rather than passive objects in the context of the public health system;

- It can also be used for validating the data collected by the ANM, Anganwadi worker and other functionaries of the public health system.

http://mohfw.nic.in/NRHM/Community_monitoring/Implementers_Manual.pdf

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Linking Community Based Monitoring with Community Based Planning

Community monitoring is a form of social audit of public health services, which facilitates active participation of people who are otherwise indifferent towards the state of affairs in the health system. There are two key factors that facilitated the inclusion of Community monitoring in NRHM. First, the architects of NRHM felt that introducing an officially sanctioned community-monitoring programme would fill a critical gap in the Mission's validation system. CBMP would act as the "third leg" in the monitoring system, joining the internal management information system (MIS) and the external evaluation surveys and audits. Second, the initiation of CBMP was significantly shaped by sustained people–oriented advocacy by networks such as Jan Swasthya Abhiyan (JSA).[5]

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5   Shukla, A., Scott, K. and Kakde, D. (2011): 'Community Monitoring of Rural Health Services in Maharashtra', Economic and Political Weekly, Vol XLVI, No 30, pg 78–85.

Further, the National Rural Health Mission envisages the health planning process to be participatory and decentralized, starting with the village community. This is based on the concept of placing the health of the people in their own hands, enabling them to determine the ways in which they would like to improve their health, and ensuring that health plans are locally specific and need based. The District Action Plan has been an important aspect of the NRHM, and to make District planning more meaningful and to address local health problems, preparation of Block Health Plans was considered essential. The decentralized planning process is supposed to involve village consultations and preparation of Village Health Plans by the Village Health, Sanitation and Nutrition Committees (VHSNCs) followed by preparation of health plan at Primary Health Centre (PHC), followed by Block level plans prepared through integration of PHC plans at the block level. The Block Action Plans including health facility surveys are then supposed to be integrated to form the District Action Plan.

NRHM has institutionalized Health facility management committees known as Rogi Kalyan Samiti (RKS), in order to promote participatory inputs to run the PHC, Rural hospitals and District Hospitals.
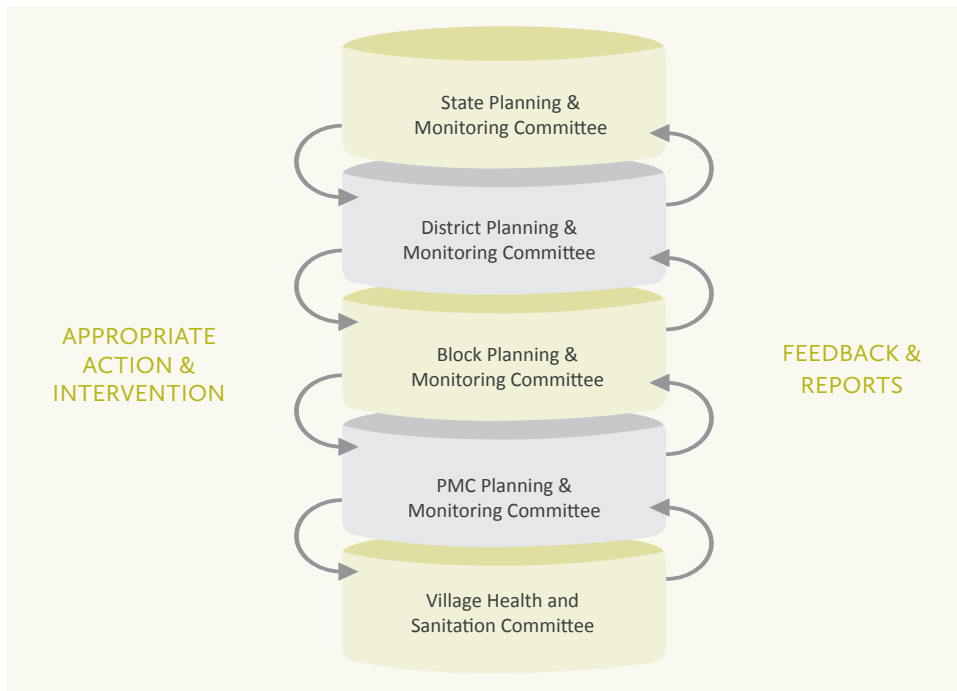
Scope and Structure of CBMP

Community Based Monitoring and Planning process is implemented as a pilot programme in selected nine states of India of which Maharashtra is one state. In the first phase (2007–09), five districts were selected, namely Amaravati, Nandurbar, Osmanabad, Pune and Thane. In the second phase (2010 onwards) of CBMP, this activity was expanded to Aurangabad, Beed, Chandrapur, Gadchiroli, Nashik, Kolhapur, Raigad and Solapur districts. At present, Community based Monitoring and Planning process is being implemented in 13 districts, 37 blocks and 150 PHCs and 680 villages across 13 districts. About 25 civil society organizations (CSOs) are involved collaboratively in implementing CBMP in these 13 districts.

Health Officials, Panchayat members, representatives of Community Based Organizations/ NGOs/ Peoples Movements, and active community members are part of Monitoring and Planning Committees at various levels. CBM processes related to NRHM are organised at the village, primary health centre (PHC), block, district, and state levels. A state nodal NGO (SATHI in the case of Maharashtra) coordinates the CBM activities across districts in collaboration with the district and block nodal NGOs, working with the state health department. A monitoring committee at each level collates the findings from the level below, monitors the health system at its own level, and passes the results and unresolved issues up to the next level two times a year (Figure 1[6])

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6   http://www.nrhmcommunityaction.org/pages/organogram/monitoring–and–planning–committee.php

APPROPRIATE ACTION & INTERVENTION

State Planning & Monitoring Committee

District Planning & Monitoring Committee

Block Planning & Monitoring Committee

PMC Planning & Monitoring Committee

Village Health and Sanitation Committee

FEEDBACK & REPORTS

STAGES OF CBMP

The Community based monitoring process includes preparatory activities, capacity building and training of trainers, community assessment, interface meetings and state level dialogue events. Some details about this five stage process are given below:

Step I: Preparatory activities

Creating an environment to facilitate the monitoring process, as well as to get mandate and co–operation from different stakeholders at different levels:

- Meetings and discussion with key stakeholders at various levels to orient them regarding processes which are going to be implemented through CBMP as well as to ensure participation and cooperation from them.

- Constitution of mentoring groups at state and district levels with inclusion of representatives from the nodal agency, health officials and civil society members for advising and mentoring the community monitoring and planning process.

BOX 2: PROPORTION OF REPRESENTATION IN THE MONITORING AND PLANNING COMMITTEES AT PHC LEVEL AND ABOVE-

- Elected members of local government bodies – 30%
- Health officials and providers – 20-30%
- NGOs/ civil society organisations – 15-20%
- Non-official representatives from lower level committees – 15-20%
- RKS (Health facility development committee) members – 10%

Step II: Formation of Monitoring and Planning Committees followed by capacity building through workshops, training and orientation meetings

- In order to carry out CBMP activities, monitoring and planning committees are formed at various levels as described earlier. These committees consist of representatives of different stakeholders like Panchayat representatives, health providers, community–based organizations (CBOs) and community members (Box 2).

- For effective functioning of these committees, capacity building of the committee members is ensured through training, orientation workshops and meetings.

- State and district level workshops are held to share the concepts, identify intervention Blocks and PHCs, with involvement of health officials, PRI members and civil society organizations.

Step III: Community feedback/assessment of health services through data collection and preparation of Report cards

- The experiences and feedback of community members is collected by developing tools and techniques like in–depth interviews, focus group discussions, case studies, record reviews and citizen's report cards.

- The report card has three colour codes based on the status of implementation of various activities and delivery of services. (Green = 75–100% activities completed or services delivered; Yellow = 50–74% activities completed or services delivered; Red = 1–49% activities completed or services delivered.)

- Data collected are complied, collated and analyzed in a standardized manner at different levels depending upon the availability of services so as to present an aggregate picture and also to have specific information about the individual service.

- Sub–groups of the committees may further monitor implementation in the field through periodic visits.

- The committees send a periodic report (six monthly or yearly) to the next higher-level committee for information and action.

Step IV: Public hearing or 'Jan Sunwai'

- In the mass accountability events, people are invited to report/present their experiences of Health services and denial of care, which is followed by response from relevant authorities.

- The Jan Sunwai (JS) is facilitated by the district and block nodal organisations in collaboration with panchayat representatives and CBOs/NGOs working on the issue of health rights.

- The authorities are required to respond to the testimonies and findings, stating how the problems will be addressed.

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Step V: Periodic state level dialogue

■ During the state level dialogues, issues that are not resolved at district level are discussed with state level officials.

■ The simultaneous participation of health officials from various levels in the state level dialogue events helps to assign responsibility to take corrective action, which is often declared during the meeting itself.

Maharashtra is one of the states included in the pilot phase of implementation of CBM, it has the distinction of being the first state in the country to include the CBMP component in its state Project Implementation Plan (PIP) in the Year 2009–10, indicating the effectiveness with which CBMP has been implemented and support from the state government.

In order to gain insights related to CBMP as a key strategy for ensuring health care entitlements, this paper undertakes an in–depth analysis of selected Jan Sunwais conducted in 2011–12 in Maharashtra and selected 'Stories of Change' emerging from the CBMP process. It tries to identify the causal factors that led to positive change (or otherwise) in health service delivery and also highlights the challenges ahead for development of CBMP in the state.

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Chapter 2

Methodology

As part of CBMP in Maharashtra, JS) have been organised at the PHC level, at block level and at district level. From March 2011 to April 2012, over 70 Jan Sunwais were held in five districts of Maharashtra. Out of these, three JS organized at different levels are selected for the present analysis: Daund PHC JS, Pune Rural Hospital JS and Nandurbar District Hospital JS. The selection is purposive, though during selection it has been kept in mind that different levels of JS have been captured, so as to allow better analysis of the causal factors. Three positive stories of change are selected, keeping similar criteria in mind.

Information for analysis has been collected from reports/minutes of JS, *Dawandi* newsletter, interviews with selected stakeholders, existing publications and discussions with the community monitoring team of SATHI. The JSs thus chosen for the analysis are from Pune and Nandurbar districts of Maharashtra. In Pune district, CBMP is being implemented in 75 villages of five blocks – Velhe, Purandar, Daund, Bhor and Junnar – from 15 PHC areas. Four NGOs, MASUM, Rachana Trust, Chaitanya and FRCH are engaged in the implementation of CBMP process. In Nandurbar, CBMP is implemented in four blocks –Akkalkuwa, Taloda, Shahada and Dhadgaon, comprising 90 villages from 18 PHC areas. Three CSOs, Janarth Adivasi Vikas Sanstha, Loksangharsh Morcha and Narmada Bachao Andolan are associated with the CBMP process in Nandurbar district.

BOX 3: THE ORIGINS OF 'AUDIT'

The term 'audit' owes its origins to the Latin word audire, which means 'to hear'. In modern times, people associate the task of auditing with financial accountants who use technical standards to examine the propriety of organizational finances. Social auditing, on the other hand, stays much truer to the original Latin interpretation of audire by requiring public officials to hear the findings of citizens regarding government programs

Chapter 3

Jan Sunwai (JS) in Context of NRHM

The MKSS (Mazdoor Kisan Shakti Sangathan) pioneered the use of Public hearing or Jan Sunwais[7] as a technique to empower villagers to 'speak truth to power', enabling them to challenge an opaque and oppressive State in rural Central Rajasthan in the 1990s. MKSS employed a range of strategies to obtain the wages owed to workers in public projects. When neither the executive nor the judicial institutions were providing redress, officials were required to make critical project documents available through public action. To leverage the information for effective advocacy and public mobilization, MKSS conceived of a forum in which village communities (many of whom were public wageworkers) could discuss public expenditures incurred in their areas. This led to the birth of *Jan Sunwais* (public hearings), also called social audits.[8] The first *Jan Sunwai* was held in December 1994 in Kot Kirana Panchayat. In this hearing, *"People who were outraged came and testified that they had never gone to those work sites, that false signatures had been used and that there were names on the muster rolls of people dead and gone, and others unheard of".*[9]

Since then, MKSS has used JS for both social audits of work done and to ascertain the reality about democratic functioning at the most tangible and immediate level: the village panchayat. It has allowed for the expression of genuine people's opinions and has empowered them, leading to an understanding of both the machinations of corruption and the way it can be fought.[10]

Since then campaigns in the country have used JS as a tool for public accountability. Schedler[11] defines public accountability as "the relationships between the power holder (account – provider) and delegator (account – demander)." There are four key elements of an accountability relationship which include setting standards, acquiring information about actions, making decisions about appropriateness, and identifying and censoring unsatisfactory performance.[12]

Right to Health Care Campaign and Jan Sunwais

Since the formation of Jan Swasthya Abhiyan (JSA i.e. People's Health Movement –India) following the 'National Health Assembly' in 2000, opposing weakening of public health systems by making health systems accountable and effective, countering commercialization of health care and ensuring access to health care for all within a broader 'Right to Health' framework has remained a strong focus of the network. JSA organized a national 'Right to Health Care Campaign' in 2003–04 which included organization of a national public consultation, documentation of

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7   Henceforth, the terms Jan Sunwai and public hearing are used synonymously.

8   http://www.justassociates.org/MKSS%20Case%20Study%20Section%20II.pdf. Accessed on 5th Sep 2012.

9   Mishra, N. (2003). "People's Right to Information Movement: Lessons from Rajasthan". Human Development Resource Center, Discussion Paper Series 4.

10   http://www.mkssindia.org/about–us/story–of–mkss/. Accessed on 4th Sep 2012.

11   Schedler, A (1999). "Conceptualizing Accountability" *The SelfRestraining State: Power and Accountability in New Democracies*. Ed. Andreas Schedler, Larry Diamond, and Marc F. Plattner. Boulder and London: Lynne Rienner Publishers, pg 13–28.

12   http://www.scribd.com/doc/75642405/Technologies–for–Transparency–and–Accountability–Implications–for– ICT–Policy–and–Recommendations. Accessed on 4th Sep 2012.

cases of denial of health care, surveys of rural public health facilities, local Jan Sunwais in some states, regional public hearings in five regions of the country followed by a national public hearing on Health rights, the last two in collaboration with the National Human Rights Commission (NHRC).[13] The national public hearing was held in Dec. 2004 in Delhi where senior health officials from 22 states were present with Union Health Minister and Central senior health officials.

In these public hearings, case studies of denial of health care were presented before the panel comprising of NHRC members, officials and JSA members. Senior health officials, of the states from which the cases arose, were made respondents in the public hearing. It was an opportunity for people who were denied health care to ask for effective action by state health authorities and investigation by the NHRC. At the national hearing, issues arising from the regional hearings were discussed, and recommendations were released by the NHRC.[14] The issues raised by health advocacy groups through these public hearings and a change in government in the Centre contributed to the launch of NRHM, which was a response to the health system crisis and the broader message given by the electoral verdict of the 2004 general elections. CBMP which was introduced in 2007 as a part of NRHM gave formal space to people to seek accountability from the health system.

Jan Sunwai: The Process Involved

a) The dates for the *Jan Sunwai are decided well in advance*, so that enough time is made available to collect necessary evidence and testimonies. The event is usually held in the public health facility itself or at a common place easily accessed by people, and the following preparations are done:[15]

- *Mobilization of people from communities*: Local organizations mobilize people and active groups from the area, so that they come for the Jan Sunwai. Their presence ensures their participation in raising issues, and is required so that they can act as a pressure group for fulfilling the demands made in the Jan Sunwai.

- *Involving and inviting Panchayat representatives:* Panchayat Raj is a system of governance based on elected local bodies, which ranges across three levels: village, block and district. At the village level, the elected council is called Gram Panchayat. The block–level elected institution is known as PanchayatSamiti. The district level institution known as the Zilla Parishad. As per the Constitution, Panchayats in their respective areas would prepare plans for economic development and promoting social justice and would execute them. Presence of PRI members in the Jan Sunwais builds political pressure for resolution of issues concerning people, and helps to ensure much needed interdepartmental coordination. Elected members to the state legislature from the area are also invited. Overall, a crucial and challenging aspect of the Jan Sunwai is to effectively involve elected members.

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13   http://www.phmovement.org/es/node/3051. Accessed on 10th Sep 2012.

14   http://www.sochara.org/new/index.php?option=com_content&task=view&id=72&Itemid=66. Accessed on 4th Sep 2012.

15   JSA (2004): Handbook One for Documentation and Presentation of Evidence Concerning Denial of the Right to Health Care; CEHAT, Mumbai.

- *Inviting government health officials:* The presence of health officials is essential for the public hearing. The Medical Officers of different PHCs in the region, Civil Surgeon (CS), District Health Officer (DHO), Additional Director of Health Services (ADHO) etc., are invited and it should be ensured that they are present at the time of JS. The level of officers invited depends on the level at which JS is organized. For example, for district level JS, officers at the level of District Health Officer (DHO) are invited. In these hearings along with health officials, officials of general administration (for example, District Magistrate, Chief Executive Officer) are also invited.

- *Constituting a panel of judges:* Prominent experts from various fields like teachers, lawyers, professionals etc. are invited for the Jan Sunwai to participate as panelists who mediate the dialogue and give an autonomous opinion or 'judgement', thus contributing to taking of key decisions during the event. The panel has a vital role to play in the JS in terms of listening to the complaints of the people and ensuring responses to them by the government officials. The panel is briefed about the purpose of JS, providing the survey findings beforehand. After listening to both the party's views, the panel gives their expert comments. The opinion of the panel members' is crucial for creating awareness amongst the people and also to pressurize the government to implement the recommendations.

- *Seeking media attention for the event*: Media play a vital role in disseminating the findings, hence it is important to contact media in advance and sensitize them in the whole process.

  As a follow–up of the JS, a meeting is usually planned with the Government officials shortly after the hearing. A small group of activists discuss the details of plan of action to improve the health services based on the recommendations. If needed, further meetings are held to ensure the implementation of the recommendations made in the JS.

> **The opinion of the panel members' is crucial for creating awareness amongst the people and also to pressurize the government to implement the recommendations.**

Jan Sunwais in Maharashtra in Context of CBMP

From 2008 to 2012, over 200 Jan Sunwais have been held in 13 districts of Maharashtra. Details are given in table below.

Table 1: Details of Jansunwais in Maharashtra (2008–2012)

Jansunwai	2008–2009	2009–2010	2010–2011	2011–12	Total
PHC Level Jansunwai	42	45	70	56	213
Block Level Jansunwai	Jansunwai was not conducted at block level during pilot phase		16	12	28
District Level Jansunwai	5	5	4	2	16
State review and culmination workshop	1		1	1	3

Chapter 4

Jan Sunwais:
Selected Case Studies

This section provides a brief description of three JS. Key insights that emerged from the Jan Sunwais is listed.

Daund Primary Health Centre (PHC) Jan Sunwai

Daund is a block of Pune district. CBMP is being implemented in 3 PHC areas since 2009 by MASUM, an organisation working on the issues of health, domestic violence, women's resource development and self-employment of rural and tribal people since 1987. A Jan Sunwai was held in Barkhand PHC on 26th March 2012. This was a PHC level JS covering Barkhand, Nangaon and Kedgaon PHCs in combined manner. This JS took into account the issues of the eight health sub–centres that come under the jurisdiction of the three PHCs.

Prior to the JS, the following strategies were used which was crucial for the success of the JS:

- Preparation and planning meeting with karyakartas (activists) in terms of taking stock of the present situation of health care services as they do regular monitoring of it, discussion of denial cases and remaining information need to be collected, logistic arrangements, village and block level mobilization.

- Documentation of the cases on the denial of health rights and analysis of data collected from PHCs.

- Authoring the report in a simple language in order to disseminate it among panel members, media persons, committee members, ZP/ panchayat samiti members and health officials during Jan Sunwai.

- Planning and orientation meeting with PHC and VHSNC committee members before Jan Sunwai.

- Orientation and involvement of local elected representatives (PRI members) including District council (Zilla Parishad or ZP) members about the CBM process and their role and responsibilities in it. Ensuring their participation in Jan Sunwais and giving responsibility to do follow up about unresolved PHC and RH level issues.

- Preparing an invitation letter and fixing date with health official, panel members to insure their presence in JS

- Inviting panel members, health officials, PHC/VHSNC committee members, Sarpanch by giving hand to hand invitation letter or through email.

- Preparation with people to present their denial cases with concrete evidence for the JS

The event: The JS was attended by Chairperson of the PS (Block level elected local body), 4 members from ZP (District level elected local body), a senior journalist from a reputed Marathi daily (Lokmat) and health activists from SATHI[16]. From government health functionaries, the Taluka health officer (THO) and medical

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16   SATHI is the state nodal NGO responsible for facilitating the implementation of CBM in Maharashtra.

officers from Nangaon, Kedgaon and Parband PHC were present to respond to the issues raised in JS. Thus one can see presence of people from diverse backgrounds, from elected representatives to government health officials. The event was organized by MASUM, the district nodal organisation.

Some of the key issues presented in the JS are as follows:

- Incomplete construction of Kedgaon PHC even after three years of beginning the construction work. This was presented in the JS. It was decided that a letter will be sent to the Zilla Parishad (ZP) Chief Executive Officer. After the JS, a follow up meeting of block health committee in presence of Panchayat committee members on unresolved issues was held. The chairperson and members of PS visited Kedgaon PHC to took stock of incomplete work and then they wrote the letter to the ZP. They also raised the issue in the District monitoring committee meeting in presence of Chairperson of Health and Construction department, ZP and District Health Officer (DHO). Following their involvement, the construction work got completed within a few months and the PHC is now delivering services.

- Inadequate outreach services by the ANM were another issue being raised at the JS. Medical Officer of Nangaon PHC promised to look into the matter and the services have improved since then.

- Death during tubectomy camp: Ratanbai Subhash Lahire went for her tubectomy operation in a camp organized by Parband PHC. She died two days after the operation. The doctor who operated on her did not disclose any thing to her relatives except telling them to take her to a higher level facility. Her family was asking for compensation (Ministry for Health and Family Welfare provides insurance to people opting for family planning operation – compensation of Rs two lakh in the event of loss of life during operation at hospital or within seven days from date of discharge from the hospital). They raised the issue at Block level and District level monitoring committee, following this JS. However, nothing happened for more that eight months. So the issue was again raised in the Stale level dialogue. The district health officer (DHO) who was recently appointed, opened the case again, looked into all the aspects and as a kind of intermediate relief ensured that the family got Rs 50,000 from the ZP welfare fund.

Pune Rural Hospital Jan Sunwai

As part of CBMP process on 9th March 2012, a JS was held at Pune District Hospital. Services of 5 Rural Hospitals (RH) of the 5 blocks were reviewed. It was a common JS for all the RH of the CBMP areas of the district instead of separate JS for each RH.

The following strategies were used for making the JS successful:

- JS of 5 RHs were combined together instead of organising them separately as it was felt that as the higher officials remain the same for each RH, and so if they are arranged separately, officials will not come again and again for each JS. This change in strategy was possible because of the flexibility that is allowed as per the need under the CBMP process.

The district health officer (DHO) who was recently appointed, opened the case again, looked into all the aspects and as a kind of intermediate relief ensured that the family got Rs 50,000 from the ZP welfare fund.

- JS was held at Pune District Hospital as this will ensure that the Civil Surgeon (CS) (District level head of Medical Superintendents (MS)) will be present for the JS.

- As the CS was newly appointed, representatives of all the Block Level monitoring committees conducting meeting with him prior to three months of the JS so as to update him about the issues as well as getting acquainted with the members of the monitoring committees.

- These interactions resulted in the CS ensuring the presence of Medical Superintendents of all blocks (including non–CBM blocks) in the JS.

- Intensive mobilization ensured that around 100 people comprising of block and PHC level monitoring committees, Chairpersons of many villages, media, lower level health functionaries and people associated with the cases being present during the JS.

- Prior to JS, block coordinators and activists meet discusses the issues to be presented. This helps in developing analytical observation skills, prioritization of issues. They also make the presentations in the JS and in turn build their confidence.

The event: The panel consisted of Co–convener of Jan Arogya Abhiyan, a senior gynecologist and a senior journalist. From government functionaries, the Civil Surgeon) and the Resident Medical Officer of District Hospital were present as respondents. Medical Superintendent of all Rural Hospitals including non-CBM areas was also present.

Some of the key issues presented in the JS are as follows:

In Saswad PHC in spite of the presence of a gynaecologist, necessary cesarean deliveries were not taking place resulting in increased cost and difficulty to the patients. This was inspite of the fact that this issue was presented in PHC level JS. It was assumed that this is because he had a political connection and thus refraining higher officials to take action against him. As this issue did not get solved even after raising at the block level, activists then raised the issue in the State level dialogue. Then eventually he was transferred and proper services are now delivered by the PHC.

Lack of proper infrastructure like waiting facilities were absent in most of the RHs was presented in the JS. The government officials solved this problem by sanctioning buying of benches from RKS funds. Other problems like lacks of clean bed sheets, toilets were also solved during the JS.

Nandurbar District Hospital Jan Sunwai

On 28th March, 2012, a special JS was organized at District hospital level. This was done as it was felt that lot of issues regarding this health facility needs to be addressed and the flexibility in the CBMP process allows for a change in the stated strategy as per the need of the area as also seen earlier in the Pune RH JS.

The following strategies were used for making the JS successful:

- Karyakartas ensured that PRI members are involved in the CBM process leading to their active participation during JS.
- Meetings of activists with monitoring committee members.
- Careful selection of denial cases for presentation.
- 200 people sent SMSs to the government officials ensuring their participation.

The event: The Jan Sunwai was attended by around 500 people. The panel consisted of the Nandurbar ZP Vice president, Pune District Coordinator of CBMP, a health activist from SATHI and President of District Anti–corruption campaign. District Health Officer (DHO) and Block Medical officers from the four CBMP blocks were present as government respondents.

Some of the key issues presented and actions taken related to these, in context of the JS are as follows:

- A mother presented the case how her sick son (affected with eye cancer) had been denied treatment in the public facilities. This moved the panel so much that people donated money there itself for the treatment of the child. The DHO responded that he would ensure whatever was possible at the district and state level facilities.
- Another key aspect of the JS was that though all the problematic issues were presented and discussed with the DHO a week prior to the JS, yet DHO had not done any homework regarding the issues and could not respond during the JS. This agitated the people present during the JS. Regarding this Munna Dada Patil (Vice president of ZP) said that he would take responsibility and review all the issues, and organise meetings with the concerned officials.

The above three JS cases highlight how the CBMP process has successfully leveraged the findings of its public hearings to build momentum around the right to health services. The significant response and participation that public hearings have generated among residents of villages shows that there has been significant support for the *Jan Sunwai* method. To summarize one can say, the operationalisation of rights, which can help citizens hold the state accountable, is most effective only when it is based on strong civil society demand.

The significant response and participation that public hearings have generated among residents of villages shows that there has been significant support for the Jan Sunwai method.

Chapter 5

Jan Sunwais:
Key Insights

The Concept: Deepening of Democracy

In the contemporary political scenario across the world, representative democracy is put forward as a political system that is shaped by the aspirations of citizens. Representative democracies rely primarily on elections as a mode of accountability. As a result, performance of representatives in protecting or promoting the interests of the voter is rarely a factor in ensuring compliance of responsibilities undertaken by the candidate. The management of voters and votes therefore remains the priority of poll managers to the detriment of genuine priorities of the people. Further the absence of the 'right to recall' at any level of representation leaves the voter powerless even when casting his / her vote to seek accountability. A strange metamorphosis overtakes the successful candidate who identifies himself / herself with the ruling regime rather than as a people's representative. As a result the current system of representation, generally deprives the citizen voter both agency and voice.

This sort of accountability has been criticized on four grounds as stated by Walker: firstly, there is information asymmetry both between elected officials and the electorate and between bureaucrats and elected officials; secondly, elections only operate ex–post; thirdly, elections only allow citizens to exercise accountability 'externally,' from 'outside' of government and lastly, citizens send representatives into government through their vote, but do not participate themselves in the tasks of government. Excessive dependence on electoral accountability has constricted accountability mechanisms and the citizen's voice has got lost in its long and complex process.[17] Indirect nature of representative democracy necessarily needs to be complemented with direct and participatory democracy.

Accountability can be analysed in the framework of vertical accountability and horizontal accountability, alternatively referred to as supply and demand side of accountability. Horizontal accountability refers to the host of mechanisms checks and balances internal to the state (judicial oversight, auditing and accounting, performance incentives) through which state agencies are held to account. Vertical accountability refers to the mechanisms through which citizens hold the state to account. When the state does not fulfil its obligations concerning rights, people are supposed to use various mechanisms to enforce these rights.[18] However, the current construction of 'rights' is recognized as an adversarial position wherein citizens have to enforce their rights against the executive, by accessing the power of the other arms of the state, namely the legislature and the judiciary to ensure compliance, while rarely exercising their collective power. Dissatisfaction with traditional horizontal and vertical accountability mechanisms, leading to the virtual disenfranchisement and disempowerment of the citizen, has triggered increased involvement of civil society in articulating demands for accountability of the state.

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17   PRIA Global Partnerships (2011): Democratic Accountability in Local Governance Institutions: Experiences from South Asia', New Delhi. Pg 3.

18   Goetz, A.M and Jenkins, R (2001), 'Hybrid Forms of Accountability: Citizen engagement in Institutions of public oversight in India', Public Management Review, Vol. 3, No. 3 (2001).

It is in this context that the Public hearing or JS functions as a mechanism to proactively seek accountability of the state, which can bridge horizontal and vertical forms of accountability. This hybrid form of accountability, which cuts across the traditional distinction between horizontal and vertical accountability, requires institutional support in the form of a legal mandate for the non–government actors to act as agents of public sector oversight, easier access to information, right of observers to issue critical reports, and the existence of clear procedures for conduct between citizen and public sector actors. The JS aims to achieve vertical accountability while energizing intra–State horizontal mechanisms. It provides a forum for justice that is more direct and accessible than the current formal justice system which is prolonged, technical and uncertain and mostly remains inaccessible for the rural and the marginalized sections of the society.

The JS experience transcends traditional accountability mechanisms by demonstrating the role that the State if willing, can play (in the form of CBM), in creating spaces which can be used by CSOs for mobilizing, conscientizing and organizing citizens to operationalize their rights. After all, CBM is about citizens exercising their right to know and participate in government affairs. JS as tool for demanding accountability is not new, but in CBM as part of NRHM, is being used for the first time to demand accountability from the state with regard to health services, through a mandate given by the state to the citizen. Civil society has an important role to play in facilitating this process. It can, as the above JSs demonstrated, enter into strategic partnerships with the state and help facilitate societal participation in the activities of government.

CBM has emerged as an effective approach, as visible in repeated JSs, to foster accountability through meaningful engagement of citizen communities in implementation and monitoring of community projects. CBM can function as a critical mechanism that empowers citizens and strengthens democratic action. For instance, the preparation of Health Report cards enables people to recognize their rights and entitlements and offers a space and mechanism through which these rights can be demanded. Neera Chandoke, in her analysis of the public hearing argues that the public hearing performs three functions intrinsic to democracy. First, it produces informed citizens, second, it encourages citizens to participate in local affairs through the provision of information and social auditing and third, it helps create a sense of civic responsibility by bringing people together to address issues of collective concern.[19] The JS ensures diverse stakeholders with different interests – community, civil society, government officials, local governance systems (PRI members), media – to come together and form a temporary alliance for a common goal, the improvement of public health services.

Accountability requires functional interface between the one accountable for (duty bearer) and the one to whom the duty bearer is accountable (claim holder) and the JS provides an efficacious platform for both to dialogue. The district level JS provides a mechanism for rural people to report the actions of their local health officers directly to the District health officer (DHO) and Civil surgeon. On the other hand, District medical officers have been able to use JS to understand the performance of staff and delivery of health services at block and PHC levels. Moreover periodic state–level conventions have

19   Chandoke, N (2007), 'Engaging with Civil Society: The democratic Perspective', Non–governmental Public Action
      Program, Center for Civil Society, London School of Economics and Political Science. Accessed from
      http://webfirstlive.lse.ac.uk/internationalDevelopment/research/NGPA/publications/WP_Engaging_Civil_Society_Web.pdf

been held, where the findings of the district JSs were presented, which puts pressure on lower level officials to implement the JS decisions before the state convention.

The state level dialogues were essential as they helped to generate state level government support for CBM and became an opportunity for the civil society groups and government to develop a working dialogue with State level officials. The participation of the state level government representatives helps to assign responsibility to rectify issues, and corrective actions may be reported during the JS itself. State officials also benefit from state level dialogues as a way to cross verify reports from the district officers against community accounts, and thus acts as an effective internal as well as external accountability mechanism.[20]

JS not only promotes egalitarian aspirations among the marginalized but it also enhances the confidence of the aggrieved person (in this case people who are denied proper health care). It makes the aggrieved occupy the public space, not for achieving personal gain, but to achieve an impact for all citizens. Thus, the JS reverses the traditional power balance, since the marginalized and the poor begin to ask the questions, while those in power like doctors, bureaucrats and other health officials are required to respond, are held accountable and on occasions are reprimanded by their own department officials. JS thereby triggers the democratic assertion of marginalized and poor communities through expansion of spaces fodemocratic engagement.

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BOX 4: PLATFORM FOR CHANGE

Prior to one JS, the MPW (male village level health worker) feared that people would speak against him, so he tried to lure people by offering them alcohol. But many more people gathered for the JS, and those who had not taken his 'favor' spoke frankly about their genuine problems. Gradually mutual trust was developed with the service providers and the MPW was reprimanded.

PHC Jan Sunwai, Amaravati.

The JS as an event tends to transcend hierarchy and thereby challenges the remote culture of the bureaucracy. The very act of placing health system deficiencies by the people in front of higher health officials serves to remove the shroud of opacity that surrounds government operations, which allows the bureaucracy to distance itself from its citizenry. It acts as a relatively equitable platform for dialogue between users and providers leading to problem solving, which has reduced the gap between administration and local people and has led to redressal of many genuine grievances and problems. For the rural poor, who are most often locked in exploitative patron–client relationships, standing up in front of local officials and expressing their grievances is no ordinary feat. Recording of health system problems through

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20 Shukla, A., Scott, K. and Kakde, D. (2011): 'Community Monitoring of Rural Health Services in Maharashtra', Economic and Political Weekly, Vol XLVI, No 30, pg 78–85.

government–endorsed report cards has restored hope among people, and in CBM areas, denial of health services is no longer silently accepted.[21]

Key Impacts:

The impact of JS activities could be seen in two spheres: first, the people are now more aware of their rights and, secondly, government officials are more answerable to them and (though sometimes reluctantly) they admit their own responsibility. By mandating the presence of officials and instituting mechanisms for regular follow up on JS findings, the JS process is an illustration of how accountability within the administrative system can be reinforced through popular actions from outside the system. It also provides a mediation mechanism between programmatic designs and systemic issues and local level implementation. For example, in a JS a question was posed what if the post of village–level health workers were vacant in villages, the existing worker would have extra workload. In that case, how would they be able to provide all the services? Moreover, subsequent to JS, people have become more aware of the importance of health services like Ante–natal check–up, hence they began to access services more often and demand for services increased.[22]

The JS cases mentioned earlier highlighted the fact that the JS is a powerful instrument to look into and provide instant relief to the people by initiating prompt action in a time bound manner. The power to affect decisions has contributed to wider community engagement, which in turn generates one of the most valuable products of CBM: social solidarity, which stimulates widening circles of consensus and commitment to work together for betterment of social services, particularly public health services. It has been seen that with the success of each Jan Sunwai, the participation and involvement has subsequently increased, as seen in the Nandurbar Jan Sunwai mentioned in the earlier section.

Another encouraging impact of JS is the increasing coordination between local self–government institutions like Panchayat Samiti (PS) and Zilla Parishad (ZP) and the Health department. For instance, in case of a partially constructed health centre, ZP health committee members have ensured that the decisions taken in JS regarding these issues were complied with in a time bound manner (Box 5).

JS process is an illustration of how accountability within the administrative system can be reinforced through popular actions from outside the system.

BOX 5: INVOLVEMENT OF PRI MEMBERS

The construction of Kedgaon PHC was incomplete even after 3 years. When this issue was presented in the JS, it was decided that a letter would be written to the ZP president. Due to this initiative within 4 months the PHC building was completed and now has been open for public.

Saswad PHC Jan Sunwai

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21   Shukla, A., Scott, K. and Kakde, D. (2011): 'Community Monitoring of Rural Health Services in Maharashtra', Economic and Political Weekly, Vol XLVI, No 30, pg 78–85.

22   SATHI (2012): *People are reclaiming the Public Health System Qualitative Report of CBMP of Health services in Maharashtra*, pg 27, Pune.

However, JS is not limited to highlighting deficiencies, though that has generally been the case in the first phase JSs. It is recognized that on many occasions the source of the deficiency lies in policy level issues, and local health functionaries may be powerless to address such deficiencies. Recognizing the constraints of the system, the Jan Sunwai (public hearing) has evolved into Jan Sanvad (public dialogue) in many areas in the second phase in Maharashtra. The modification of approach has encouraged cooperation of health officials, and has moved the discourse towards affirmative action and not just fault finding. In fact some medical officers from non–CBM areas recognizing the positive outcomes of the process have started asking for implementation of CBM in their areas (Box 6: Demand for CBM by officials).

> It is recognized that on many occasions the source of the deficiency lies in policy level issues, and local health functionaries may be powerless to address such deficiencies.

BOX 6: DEMAND FOR CBM BY OFFICIALS

The Medical officers association in Nandurbar district initially boycotted the CBM process, since they considered this to be a fault-finding exercise, and they did not like the idea of people publicly questioning them and making them answerable. However, our aim to improve health services was clear and we persisted in our dialogue with them. Gradually the misunderstandings among the doctors got cleared and some of the most vocal opponents of CBMP have now become active participants in the process. So much so, Dr. Dani, Medical officer in Shahana PHC, which is not covered by CBM, has strongly urged us to initiate community monitoring processes in his area also.

District Coordinator - CBMP, Nandurbar

Jan Sunwai: Strategies and Factors Contributing to Success

In this section, we analyze the factors that lead to the success of JS as a tool of CBMP in Maharashtra. It also draws the conscious strategies adopted to make CBMP a success.

The presence of a large number of community members is an important factor enabling the success of any JS. It creates moral pressure on the health officials and compels them to respond positively and not make false promises. The nodal agencies associated with CBM ensure that monitoring committee members, PRI members are present in the JS Specific cases of denial of health care are selected and presented by the affected persons themselves, providing concrete information. Guidance is given to persons making a complaint on presenting the case with evidence in order to make it effective. Speakers are discouraged from making unsubstantiated allegations, derogatory and abusive language is prohibited, and traditionally disempowered groups, including women, members of oppressed caste

> The presence of a large number of community members is an important factor enabling the success of any JS. It creates moral pressure on the health officials and compels them to respond positively and not make false promises.

groups and the poor, are actively encouraged to contribute their points of view. All these help to build momentum before the JS and ensure active participation.

The strategy adopted for the success of the JS is its locus of action at multiple levels. Although some public hearings were organised by health activists even before CBM was recognized as an official component of NRHM, it did not enjoy the level of success in addressing the problems. Though, the JS was able to highlight the deficiencies in the health system and cases of denial of health care. Following the initiation of CBM however, since each JS is followed by a presentation of the unresolved issues at the higher-level JS, lower government officials began to take them seriously, knowing well that their supervisors would hear of the unaddressed problems subsequently. Moreover, after recognizing that CBM is an officially mandated ongoing process, the PHC staffwas compelled to attend and take decisions seriously. For instance, Shirdhon PHC ambulance was unused for more than a year, for lack of funds to buy new tyres. Once this issue was presented in the District JS, the DHO immediately sanctioned necessary funds, knowing that otherwise it would get presented in the state JS.

In fact, most of the times the approach of the nodal NGO has been to strategically involve the higher officials prior to the JS. As seen in the case of Pune RH Jan Sunwai, where the Civil Surgeon, the highest health official at the district level, was met prior to the JS and he subsequently send a memo instructing all Medical Superintendents of all blocks including non–CBM blocks to attend the JS.

Another strategy that is employed is to publicly felicitate during the State level culmination workshop, the Public health staff members, who have taken extra effort to ensure that JS decisions are followed up, and have shown exceptional initiative for improving the quality of health services.

...recognizing that CBM is an officially mandated ongoing process, the PHC staffwas compelled to attend and take decisions seriously.

BOX 7: INNOVATION EMERGES FROM JAN SUNWAI

Subhash, a TB patient was admitted to Ganjad PHC for treatment. He was given a saline infusion, but when the bottle emptied no one was around to replace it. He was very frail and weak and was unable to get up and call the nurses, who are located in a separate nearby building. Blood in his vein climbed up slowly through the IV set. Fortunately, before any damage could take place, a nurse came and removed the bottle. Subsequent to the testimony by Subhash, participants in the Jan Sunwai discussed this and came up with the innovative idea of installing a mechanically operated table bell beside every bed. This technique was not costly and also does not need electricity, and now enables patients to call the nurses in time of need.

Report of Ganjad PHC Jan Sunwai

Involvement of the media is yet another part of the strategy employed for the success of JS in Maharashtra. In fact as part of CBM, media fellows were oriented on CBM–related activities, followed by a state level workshop which gave the reporters better a understanding of issues related to quality of health care. During JS, health services data is distributed to journalists and in some cases journalists are invited as panelists, as was the case of Saswad JS. Following the JS, briefings were given to media personnel. Due to continuous engagement with NHRM issues, media has responded by giving prominent coverage and in the process created pressure which helped in implementation of JS decisions.

The willingness of people to participate in the JSs, where in some hearings over 500 people have gathered to participate and to express their grievances, is to a large extent a result of the fact that corrective action is often taken promptly. As Dr Satish Pawar, Joint Director, NRHM Maharashtra says, "Let us use the CBM process to help solve problems through mutual understanding. This process helps articulation of people's expectations from the health system to fulfil its expected tasks, hence medical officers should avoid getting into unnecessary disputes".[23]

Due to continuous engagement with NHRM issues, media has responded by giving prominent coverage and in the process created pressure which helped in implementation of JS decisions.

23   SATHI (2012): *People are reclaiming the Public Health System Qualitative Report of CBMP of Health services in Maharashtra*, pg 47, Pune.

Chapter 6

Stories of Change Related to the CBMP Process

It is a well-known fact that the most important feedback on what, where and how health services are needed   and should be provided or improved can be given most efficiently by the users / beneficiaries of the services themselves. Community based monitoring under NRHM places people at the centre of the process and enables them to give such feedback in a regular, organised and systematic manner. Thus, this process has been able to bring about many positive changes in the realm of health service delivery.

In this section, we describe three cases of positive change brought about by the CBMP process, with a view to draw lessons about how accountability processes can induce change in health systems.

Nasarapur PHC: From 'Official Based Planning' to 'Community Based Planning'

In Nasarapur PHC in Bhor block of Pune district, it was found that NRHM flexible funds were being spent by officials even without getting mandatory sanction by the RKS (Health facility management committee). RKS members revealed that no committee meeting had been called since its formation, and medical officers were taking all the decisions themselves regarding utilization of funds. Shivaji Konde, elected representative and President of the RKS, came to know about the role of the committee following the CBMP orientation program, and he spoke to doctors and insisted on regular convening of planning meetings by the RKS and circulation of decisions of each meeting to all members. Civil society representatives of the Block Monitoring and Planning Committee were invited for the first time to the RKS meeting on 12th December 2011, where they actively participated and made several proposals, which led to the RKS committee taking a number of positive decisions. The result of this were seen within few months as the following changes have taken place:

■   Earlier there was no display board displaying the name of the PHC and it was difficult for any new patient to find the facility as it is located in an old building. Now through the RKS fund a board has been prepared and put up in a prominent location.

■   There was a serious problem of water that was pointed out. Now four water tanks have been installed in the PHC. The toilets were non–functional and were cluttered with materials, due to lack of water. Now these are cleaned and functional.

■   In order to make the laboratory fully functional, a tank for water storage was purchased, a cupboard and a new pipeline for laboratory was installed; now the complete range of tests is being conducted by the lab.

■   The post of sanitation worker which was vacant in the PHC for quite some time was addressed by appointing a worker on contract basis using RKS fund.

■   A workshop on the role of adolescents in the development of village health was conducted for school children from two villages using the RKS fund.

KEY INSIGHTS:

- Certain issues like cleanliness, availability of water and information board are very important from the community point of view, but were not recognized or considered relevant by officials during planning. This experience showed that if the space for community based planning is provided, local organizations, PRI members, and community members can suggest genuine community priorities leading to improved planning for health facilities within the specified framework.

- Bringing together key stakeholders including elected representatives in the process created social momentum for more responsive planning, besides suggesting actionable issues.

- CBMP which relies on the concept of co–management, incorporates community participation at a higher level and gives the community greater control over its own public facilities.

- CBMP process in health service delivery is more effective because it incorporates the relevant knowledge and experience of those affected by lack of proper health care. In this way, participation can help to resolve existing conflicts, and can empower the community to take a more active role in proposing possible solutions to problems.

Similar experiences of community based planning are being reported from other CBMP areas, making it evident that through the CBMP process, information generated through community monitoring is now being contributed to enhance popular participation in the local health planning process. Through this process, the health system is also realizing that ordinary people do come up with appropriate and innovative ideas to improve health services, and such proposals are being formulated for inclusion in district level PIPs.

Bringing together key stakeholders including elected representatives in the process created social momentum for more responsive planning, besides suggesting actionable issues.

From a Half Built to Completed Sub Centre

A sub–centre (SC) was sanctioned for Jamshet village of Dahanu Taluka in Thane district but the 'politically connected' contractor who was supposed to build the SC, stopped construction after building the SC half way. It had remained incomplete for more than two years. This issue was raised in four consecutive village meetings, as also at the block level monitoring committee meeting, but nothing changed. At last, villagers decided that they would build it through voluntary labour or *shramdan*[24]. One morning, around a hundred people gathered in front of the SC with construction tools to complete the construction. Once the Vice– Chairperson of GP (village level elected body) and *Gramsevak*[25] came to know about this, they rushed to the sub–centre along with the contractor. They apologized to the villagers and the work started on that very day. Now the SC built with the services rendered and accessed by villagers. An additional ANM was posted and significant numbers of deliveries are being performed in this sub–centre now.

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24   *Shramdan* means putting in collective labor voluntarily to achieve some public good.
25   *Gramsevaks* are appointed functionaries who perform the work of the secretary to the Gram Panchayat.

KEY INSIGHTS:

- Shift in balance of power: with the system failing to complete construction of the sub–centre, people took the issue into their hands and this signifies a major shift regarding 'who is in–charge'. The threat of people taking things into their own hands provoked a prompt response from the system.

- Reclaiming elected representatives: Elected members have recognized that they cannot get away with incomplete work and hope to get re–elected. This has been one of the main reasons for greater involvement of members of local governance structures like Gram Panchayat, Panchayat Samiti and Zilla Parishad, with the CBMP process. CBMP is seen as a form of promoting direct democracy that can also make representative democracy work better.

- The CBMP process has been able to instil confidence among the community, who are now not afraid to confront the system. The process has created a valuable space for community to pursue issues, follow them up, and make improvement in public health service delivery.

  In fact going beyond health care, the concept of CBMP is now getting internalized in the minds of people, and is being used to monitor other social services like nutrition and mid–day meals to name a few.

> CBMP process has been able to instil confidence among the community, who are now not afraid to confront the system. The process has created a valuable space for community to pursue issues, follow them up, and make improvement in public health service delivery.

Treatment for Diabetes and Hypertension at the PHC

A workshop was conducted at Malshiras PHC as part of the CBMP process. Among the participants were Radhabai and Sushilabai. With very low earnings and no family support, they were not able to afford cost of diabetes medicines, even the small cost of Rs 20 every 10 days, nor could they afford to spend on travel to the nearest government rural hospital for the same. Based on suggestion given by the CBMP committee members, the Medical officer of the PHC took initiative, investigated patients, and with the help of a specialist doctor started a monthly medical camp in the PHC for diabetes and hypertension patients.

After positive responses from the community to these camps, and in order to sustain this activity, a proposal to ensure supply of relevant medicines was prepared and submitted by MASUM – the District CBMP civil society organization and the PHC Medical officer, and this was included in the district PIP. However this genuine demand did not get included in state PIP. In spite of this, the issue was again strongly raised in the District Monitoring and Planning meeting. After regular and continuous dialogue with the Chairperson of the Zilla Parishad Health Committee, he took the proposal forward and with the help of District Health Officer, funds have been allocated from the Zilla Parishad to supply these medicines. Now due to this initiative, medicines to treat hypertension and diabetes are now being made available in 22 PHCs in Pune district.

KEY INSIGHTS:

- An important health service priority, which was not picked up through routine health planning, was identified through CBMP process.

- The CBMP process expanded the scope of available services at the PHC beyond its traditional mandate.

- Community and civil society members, elected representatives and the local medical officer all came together to respond to a genuine health need expressed by the community.

- The PIP preparation process, which is supposed to allow space for decentralised planning also failed to respond to this genuine need; then due to push from elected representatives this was met from district level elected body funds.

  The above case shows that CBMP has begun to expand the perimeter of available health services at the health facilities beyond the traditional mandate. It is also gradually winning people back to the public health system, helping them to escape impoverishment from health care expenditure.

Community and civil society members, elected representatives and the local medical officer all came together to respond to a genuine health need expressed by the community.

Linkage between CBM and CBP – Synergy Between These Two Approaches

While Community based monitoring (CBM) in Maharashtra has been successful in highlighting the deficiencies in functioning of health service delivery, change/ improvements in different facets of health delivery, it is also important that these findings are discussed in the local level planning bodies and suitable solutions to the problems are conceived through the Community based planning process (CBP). There is a close and mutually reinforcing (supportive) relationship between monitoring and planning; neither of the two can be carried out effectively in isolation from the other. While monitoring provides information for project planning and implementation, decisions taken through planning provide the basis for further monitoring of their implementation. For instance, while CBM has highlighted how untied funds are not being used for the said purpose, CBP has been able to find effective solution for the use of the funds to achieve the desired goals as seen in the Nasarapur PHC story earlier.

Success of CBM and CBP process with regard to health service delivery fosters a sense of ownership, and generates commitment within the community and is self–reinforcing. The effective use of locally collected information generated through CBM and the power to change decisions through CBP, leads to stronger and wider community engagement.

There is a close and mutually reinforcing (supportive) relationship between monitoring and planning; neither of the two can be carried out effectively in isolation from the other.

Chapter 7

Conclusions:
Lessons Learnt and
Further Steps

The above sections highlight how JS have become a key tool for CBMP of health services in Maharashtra, leading to positive changes in health service delivery as is evident from the stories of change. This approach is consistent with the 'Right to Health Care' approach since it places health rights of the community at the centre of the process. It seeks to enforce health rights by addressing gaps in the implementation of various programs, while enhancing transparency down to the grassroots. It is an important approach for promoting community–led action and can act as a powerful mechanism to promote accountability and stimulate responsive, accountable and transparent local governance. This case study of JS in particular and CBMP process in Maharashtra in general, provides key lessons which can be relevant for groups working on accountability of health services in other contexts as well. Based on the Maharashtra experience, some key lessons learnt are presented below.

Ensuring high levels of community participation and ownership in the CBMP process

- Develop community involvement through innovative and interactive community based dialogue processes.
- Involve facilitators from civil society organisations with prior experience of health rights and social accountability work.
- Keep the monitoring tools simple – use pictorials/adopt local terminology to describe different measures of performance.
- Enhance cooperation among the community members, local elected members (PRI members) and public services providers, with fulfillment of people's health rights as the central objective.

Promote accountability and responsiveness

- Build mechanism(s) that promote ongoing dialogue about quality and performance between users, community based activists, providers and local government for example, meetings of community monitoring committees.
- Incorporate forums that provide opportunities for interaction between community members and health officials with space for concrete decision making, for example, JS
- Combining community monitoring with community based planning results in better programme planning with use of local knowledge.

Build provider support for performance monitoring

- Create a problem–solving culture and address performance gaps from the perspective of lessons learnt and how to felicitate publicly responsive providers, encouraging good performance.
- Important to keep focus on action and results – ensuring that communities and providers move beyond the scoring to focus on concrete changes required.

Formal sanction for CBMP process by the government

- CBMP process has official sanction, which makes it mandatory for the government officials to participate in the process.

- Officially mandated dialogue process at multiple levels, for example, JSs at PHC, Block and District levels improve effectiveness of the process.

Further Steps Required to Carry the CBMP Process Forward

Despite the undeniable positive impacts of CBMP, the process is still in a nascent stage. There are different phases in the change process; initially change may unfold in the desired direction probably due to 'novelty' of the intervention and the energy generated in the community due to the initial interventions. However, in processes like CBMP which impact on social hierarchical relations – there will be resistance and the speed of change may reduce with time, and the direction of change may even get reversed. CBMP contains the seeds for empowerment of the marginalized, but if this process does not contribute to continued incremental improvements, then people's enthusiasm for participation will decrease.

Hence, a key challenge in this process is to continually ensure positive health system responses to issues raised by community members, with increasing responsiveness of the health system over time. This depends on health officials at various levels taking ownership of the process and getting actively involved in them, with adequate space given to the CSOs and activists to effectively promote pro–people change. The State Health Department of Maharashtra has internalized certain level of ownership of the CBMP process, which in combination of civil society efforts has made many changes possible. Building on the positive processes so far, in order to carry forward CBMP in Maharashtra, further actions on several fronts are required which are listed below:[26]

- *Regular, periodic multi-stakeholder reviews* – There is need to conduct regular CBMP reviews at state and national levels to take key process related decisions, and to tackle issues that need to be resolved for ensuring that community action continues to be developed effectively.

- *Removal of constraints on civil society representation on CBMP bodies* – During the last few years the mandate and proportion of CSOs in key CBMP bodies (such as state and district mentoring committees) is reduced. For instance, while constituting the State mentoring and planning committee, civil society representation has been truncated compared to national guidelines. Such reduction of civil society roles must be reversed, since this will lead to constriction of participation in the CBMP process.

- *Phased modification of role of CSOs instead of 'exiting' them* - As seen in the earlier sections, CSOs play a crucial role all phases of CBMP process. Now in CBMP areas people are gradually coming forward to claim their health rights. Given this situation, CSOs need to modify their involvement, moving from intensive roles to lower intensity roles, especially in areas where the process is underway for more than four–five years. Hence guidelines need to be developed how after a defined period, CSOs should move to giving lower intensive inputs in a 'consolidation and maintenance' phase. However, the tendency of certain officials to insist on 'exit' of

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CONCLUSIONS: LESSONS LEARNT AND FURTHER STEPS

CSOs would damage the entire process, and must be replaced by an appropriate transition policy.

- ■ ***Need to further enlarge spaces for decentralized planning-*** CBMP committee members have taken initiative to provide inputs to RKS and local PIP processes. However medical officers still continue to largely dominate the planning process. In Maharashtra, there are instances where suggestions from the committees formulated through CBP process have been endorsed for the annual PIP at lower levels like districts, only to be eliminated from the finalized State PIP by higher officials. This situation needs to change if CBP is to become a reality in context of state PIP development.

- ■ ***Need for more effective grievance redressal system-*** Provisions which can enable community members to directly demand accountability like institutionalizing participatory forums for accountability like Jan Samvads (public dialogues) need to be operationalized.

- ■ ***Addressing systemic and structural health system issues-*** CBM should not be viewed as the sole strategy for improving rural health services. The effectiveness of CBM is linked with the basic functionality and social responsiveness of the public health system. On its own CBM will not be able to effect drastic improvements in areas where deeper structural barriers or systemic constraints are operative, for instance deployment of adequate number of doctors at rural health centres. There is an urgent need to address key public issues afflicting the public health sector.

- ■ ***Need for CBMP to become a higher priority for the Public health system-*** Experience of CBMP in Maharashtra has shown that though state level officials are supportive of CBMP, they are preoccupied with diverse responsibilities. Since decision making for certain CBMP processes is dependent on them, this often leads to delays. There is need for deeper understanding and proactive commitment among the government officials at all levels to ensure that CBMP is given adequate priority.

This paper has sought to present key issues and experiences related to Community based monitoring and planning in Maharashtra, and has shown that despite myriad hindrances and challenges, rural people who earlier had no say or participation in the local health system, are now speaking up. The voice of the voiceless is now breaking the cycle of apathy among both people and the bureaucracy, widening accountability channels and deepening local democracy.

On its own CBM will not be able to effect drastic improvements in areas where deeper structural barriers or systemic constraints are operative, for instance deployment of adequate number of doctors at rural health centres. There is an urgent need to address key public issues afflicting the public health sector.

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